CAREER DEVELOPMENT & RECENT ADVANCES IN GERIATRIC SERVICES IN HONG KONG

Dr CP Wong
Chairman, Geriatrics Subcommittee
Hospital Authority
Outline

- The Elderly Health Service Demand
- Man Power in Geriatric Medicine
- Recent Advances in Geriatric Services in HK
  - Aging Research
  - ACE
  - HARRPE
  - ICDS
  - Call Center
  - Geriatric Rehab
- Conclusion
## Population Growth in Hong Kong

<table>
<thead>
<tr>
<th></th>
<th>Non-Elderly (&lt; 65)</th>
<th>Elderly (65+)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(as % of total population)</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>6,156K</td>
<td>912K (13%)</td>
</tr>
<tr>
<td>2016</td>
<td>6,270K</td>
<td>1,165K (16%)</td>
</tr>
</tbody>
</table>

Increase:
- Non-Elderly: 115K
- Elderly: 253K

1 VS. 2.2
Risk of Hospitalization

Non-Elderly (< 65) vs. Elderly (65+)

0.6 in 10 ever hospitalized in general specialty in 2010*

Relative risk of hospitalization: 1 vs. 4.2

* General Specialty refers to Care Category: Acute General or Convalescence/Rehabilitation. Age 0 are excluded in the calculation of hospital services utilisation.
Figure 4. Projected public and private health expenditures up to year 2033

Source: Hong Kong’s Domestic Health Accounts: Financial projection of Hong Kong’s total expenditure on health from 2004 to 2033.
Growth of Consultant Geriatricians
Retiring Geriatricians in < 5 years

- Wong, Ip, Leung, Chu, Dai, Kong …
- More retiring SMOs
- Should induce another surge of trainee intake
15 Trainees
176 Fellows (138 working in HA)
USA standard 5.5/10,000 >75 elderly
- HK 176/476,572 = 3.7
UK 1/4,000 >75 elderly
or 1/35,000 population (1/50,000 if full time without general medicine work)
- HK 176/7,000,000 or 0.88/35,000
- Or 1.47/4,000 > 75 elderly
Future Career

- Wait for the retirement gap
- Age Research
- Community Services
- Geriatric Rehabilitation
- Health Administration
Previous Development

- Rapid Expansion of Geriatric Services 75-
- Scottish Model
- Integration with Medical 92-
- CGAT 94-
- Geriatrics Education 99-
Present Development

- HARRPE 06-
- IDSP 08-
- ACE 09-
- CHCC 09-
- ICM 11-
ACUTE CARE MODEL FOR ELDERLY
In-patient Care
Lasting Impact on Elderly Patients

Common elderly problems:
- Adverse Drug Reactions
- Pressure Sore
- Falls
- Use of Restraints
- Delirium and impaired cognitive function

If suboptimal care

Deterioration in
- ADL
- Mobility
- Confidence
- Mood
- Nutritional status
- Incontinence

Increase hospital readmissions
Strengthen Care of Elderly in Acute Setting

1. Development of best practice in a hospital wide joint team approach to **improve quality of care, prevent deterioration and complications in acute settings**, especially for higher risk elderly patients
   - Early detection and appropriate interventions
   - Multi-disciplinary input for complex cases
   - Reduction of iatrogenic events during short stay
   - Training of care staff to enhance geriatric care

2. Facilitation of early discharge and gap-free transition into the community; better discharge & care plans and continuity of care
Development

- Clinicians, Nurses, Allied Health
- Inter-disciplinary representatives, Acute and Non-acute settings
- Management executives

Geriatrics Subcommittee

Task Force on ACE

Working Group on ACE

10 Sub-groups on individual protocols
10 Important Care Processes Identified

Identified through-

- Disease burden & service gaps
- Priority in system: KPI, Hospital accreditation criteria
- Staff & patients’ views
- Peer & Literature Review

1. Fall
2. Discharge planning
3. Pressure Sore
4. Nutrition and enteral feeding
5. Urinary incontinence
6. Medication management
7. Acute confusion
8. Cognitive impairment
9. End of life care
10. Rehabilitation Potential
ACE Protocols: Outline

- Assessment; Risk stratification and referrals; Integrated with existing nursing assessment
- Set Guiding Principles & Minimum Care Standards
- Formulate interventions & care pathways
HOW THE ACE PROTOCOLS HELPS?
Fall and related acute injury in ward:

- Patient suffers
- Staff: stress and workload
- Hospital: Prolonged LOS
- AIRS, KPI report, Hospital accreditation criteria
- Cause of complaint and legal issue
Current Situations

- Already taken a lot improvement initiatives, including improvement in nursing care
  - Some hospitals: with standardized risk assessment tools applied to all patients; automated care pathway and care support

- Gaps
  - Still variations in practice:
    - E.g. Not all hospitals/ units are using validated tools
  - Identified high risk elderly: may not be able to illicit timely multidisciplinary team support
  - Non-M&G wards: less focused on conditions/risk factors common in elderly patients
ACE protocols

A systematic approach, care standard & a tool to coordinate joint effort

- Improve fall risk prediction by validated screening tool(s)
- Promote staff awareness for at-risk patients and patient empowerment
- Illicit fall prevention measures
- Ensure timely assessment and intervention to patients at higher risk, activation of multidisciplinary team when indicated
- Ward environment and facility adjustment
- Interface with ICM, rehabilitation or community services
- Promote improvement also in other acute wards
Falls: Pathway

Patient admitted to acute wards (because of fall or other diagnosis)

Initial Screening (usually by ward nurses)

Low Risk – Continue Usual Care

High Risk – Targeted Intervention

Activate Multidisciplinary Team Assessment

Rehabilitation Wards, Geriatric Day Hospital, Fall Clinic or other Fall Prevention Program

Use of Validated Tools to Identify Patients at High Risk of Falls

Activate Protocol-based Care Pathway; Draw in input from multidisciplinary team
- More comprehensive assessment of risks
- Fall precaution measures
- Environmental adjustment
- Modification of underlying causes. E.g. Drug review, Mobility assessment, Cognitive assessment
Rehabilitation & discharge support planning
Implementation

- Emphasize working together as team with doctors, nurses and allied health
- Refine protocols, consult and roll out to non-medical wards
- To promote Fall protocols (in acute M&G wards +/- other wards)
  - KWH, PMH, TKOH, PYNEH, RH, TMH
- Training of staff
  - Nurses
  - Allied health
  - HCAs
- Equipment and facility
TACKLING UNPLANNED READMISSIONS
70% Unplanned Readmissions are Elderly

~100,000 unplanned readmissions per year

Elderly
Study by the Chinese University of Hong Kong on Reducing Avoidable Hospitalization

- Literature review
- Review of relevant HA programs & practices
- Medical record review
- Questionnaire surveys with patients
- Focus group / interviews with patient and staff

Care Coordination:
- Failure of post-discharge follow-up care

Quality of Care:
- Premature discharge

Social Factors:
- Lack of support and community services
- Lack of an integrated and coordinated system
- Poor communication & patient involvement

Strategy & Planning Division
Hospital Admission Risk Reduction Program for the Elderly (HARRPPE)
Index Episodes of target subjects

Patients aged 60+ who are alive upon discharge from either of the following 4 types of index episode:

1. Attendance at emergency department for medical conditions (without admission)
2. Emergency admission to acute medical ward (including those transferred from EM Ward)
3. Elective admission to acute medical ward
4. Attendance at medicine specialist outpatient clinic
Index episode

An encounter with elderly during:
- Attendance at A&ED for medical conditions
- Emergency admission to acute medical ward
- Elective admission to acute medical ward
- Attendance at medicine specialist outpatient clinic

Discharge Alive

Look back period

Day 0

Look forward period

Day 28

Risk Prediction Model

14 Predictors:
- Socio-demographics
- Prior utilization in past 1 year
- Co-morbidity
- Type of index episode

To predict the probability of emergency admission to acute medical ward in 28 days ahead

Risk stratification
Modelling Methodology (2)

**Predictor variables**
- Clinical relevance sourced from literature review
- An expert panel of geriatricians
- Data availability and quality in the corporate administrative and clinical information systems

**Outcome Event**
Emergency admission to medical ward of any HA hospital within 28 days after an index episode in which the elderly patient was discharged alive.

**Multiple Logistic Regression**
- Model the relationship between the outcome and the predictor variables.
- Estimate the relative weighting of individual variable in calculating the predicted probability of emergency readmission to medical ward.
Model development and validation

Training Dataset
1.37 million index episodes of target subjects in 2005

4 Validation Datasets
4 quarterly cohorts in 2006 (each with a complete coverage of over 0.3 million index episodes)

Model building

Model

Model validation
The HARRPE score

- is the predicted probability of emergency admission to medical ward of any HA hospital within 28 days after an index episode, in which the elderly patient was discharged alive.
- the higher the score, which ranges from 0 to 1, the higher is the likelihood.
Model Results – an Overview

- The outcome event rate was **7.2%**
  - 98,600 medical emergency admissions within 28 days after 1.37 million index episodes in 2005

- A total of 14 clinically and statistically more significant (each with p-value < 0.0001) predictor variables were chosen in the final model
Who will be more likely to have a medical emergency admission in 28 days after discharge?

With the following socio-demographics:

- Male
- Older (Age: per 1 year increase)
- On CSSA

With higher prior service utilization in the past one year:

- A&E attendances (MED) without admission
- A&E admissions (MED) [unplanned readmission in 28 days]
- A&E admissions (MED) [NOT unplanned readmission in 28 days]
- Acute patient days (MED)
- Non-acute patient days (MED)
Who will be more likely to have a medical emergency admission in 28 days after discharge?

Presence and higher number of co-morbidities

- COAD (ever coded in CMS)
- CHF (ever coded in CMS)
- Cancer (ever coded in CMS)
- With renal dialysis treatment or not (in the past 1 year)
- Number of distinct diagnosis groups (by an operational counting rules based on codes ever captured in CMS)

* CMS refer to Clinical Management System currently used in the Hospital Authority
Model Performance (1)

- The model achieved an area under receiver-operating characteristic (ROC) curve at
  - 0.828 for training dataset
  - 0.819 – 0.824 for 4 validation datasets
Observed vs Expected Outcome (28-day A&E Admission) by Interval of Predicted Risk

<table>
<thead>
<tr>
<th>Encounter Type</th>
<th>Predicted Risk</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.0 - 0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Total</td>
<td>901,749</td>
<td>145,027</td>
</tr>
<tr>
<td>Observed Event</td>
<td>30,092</td>
<td>21,670</td>
</tr>
<tr>
<td>A&amp;E 1st attendance (MED) (without admission)</td>
<td>10.2</td>
<td>14.8</td>
</tr>
<tr>
<td>IP(MED) - A&amp;E admission</td>
<td>2.8</td>
<td>35.4</td>
</tr>
<tr>
<td>IP(MED) - Non-A&amp;E acute admission</td>
<td>3.7</td>
<td>16.1</td>
</tr>
<tr>
<td>Others - SOP(MED)/FMRIC</td>
<td>83.4</td>
<td>33.7</td>
</tr>
</tbody>
</table>
**Hospital Admission Risk Score**

- Based on 14 clinical predictors
- Higher the score, higher the likelihood of readmission
- Support focused attention to patients at risk and in need

<table>
<thead>
<tr>
<th>Socio-demographic</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Old</td>
</tr>
<tr>
<td></td>
<td>On social security</td>
</tr>
</tbody>
</table>

| Prior service utilization in the past one year | A&E attendance | Acute & non acute admission | Acute and non acute hospital stays |

<table>
<thead>
<tr>
<th>Presence and number of Co-morbidities</th>
<th>Chronic obstructive airway disease</th>
<th>Heart failure</th>
<th>Cancer</th>
<th>Ever treated with renal dialysis</th>
<th>No of different diagnosis groups on records</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Types of current hospital discharge</th>
<th>Types of current hospital discharge</th>
</tr>
</thead>
</table>
Workflow of CHCC

Auto-filtering for “65+ MED patients discharged alive with HARRPE score $\geq 0.17$”

Daily list of eligible patients for CHCC follow up

CHCC nurse proactively call the patient within 48 hours

Target clients’ key discharge issues

Physical condition

Medication management

Remind follow up appointment

Community resources need

If medical problems exist

Nursing assessment based on protocols

Advice to appropriate health & community resources

Documentation of problems, protocols used and advice
### 80 Clinical Protocols

- Abrasions
- Allergic Reaction
- Altered Level of Consciousness
- Ankle Problems
- Anxiety
- Arm or Hand Problems
- Asthma
- Bone, Joint and tissue Injury
- Bruising
- Decreased general condition
- Dehydration
- Depression
- Domestic Abuse
- Eye Injury
- Eye Problems
- Facial Pain
- Fainting
- Finger and Toe Problems
- Foot Problems
- Gas/Flatulence
- Head Injury
- Hearing Loss
- Heartbeat, Rapid
- Heartbeat, Slow
- Heartburn
- Hoarseness
- Hypothermia
- Jaundice
- Jaw pain
- Knee Pain/Swelling
- Mouth Problems
- Muscle Cramps
- Nausea/Vomiting
- Adult Neck Pain
- Nosebleed
- Overdose
- Refused Feeding
- Scabies
- Seizure
- Shoulder Pain
- Sore Throat
- Stools, Abnormal
- Suicide Attempt, Threat
- Swelling
- Tongue Problems
- Toothache
- Urination, Difficulty
- Urination, Painful
- Urine, Abnormal Color
- Vision Problems
- Wheezing
- Wound Healing and Infection
Performance Measures

- % of inbound call answered: 93%
- % of inbound call flow out to voice mail: 4%
- % of abandon call: 3%
- Within Service Level %
  (20 Sec answering the call): 91%
Collaboration is the KEY!

NGOs
District Elderly Care Center

GOPCs

GPs

Volunteers

Community Allied Health

Community Nursing Service

Hospital Service
Advices Given / Arrangements Made

Whole Cluster Based Support
Education Given / Month

- Health Education
- Drug Management
- Home safety advice
- Information on community resources

No.
## Study vs Control – Baseline characteristics

<table>
<thead>
<tr>
<th></th>
<th>KCC Study Cohort</th>
<th>NTWC Control Cohort</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of subjects</td>
<td>429</td>
<td>538</td>
<td></td>
</tr>
<tr>
<td>Mean age at admission</td>
<td>79.6</td>
<td>79.5</td>
<td>0.9349</td>
</tr>
<tr>
<td>% Male</td>
<td>58.0%</td>
<td>58.4%</td>
<td>0.9196</td>
</tr>
<tr>
<td>Mean HARRPE risk score</td>
<td>0.333</td>
<td>0.334</td>
<td>0.8483</td>
</tr>
</tbody>
</table>
Results

Based on the statistical model,

<table>
<thead>
<tr>
<th>Outcome Measures</th>
<th>Incidence^1</th>
<th>Count^2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Admission to Medical Ward^</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Acute Patient Days in Medical Ward</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Attendance in A&amp;E Department#</td>
<td>*</td>
<td></td>
</tr>
</tbody>
</table>

Notes:
1. No. of patients with any attendance in Accident & Emergency Department / emergency admission to medical ward / acute patient days in medical ward during the 90-day post-discharge period
2. Average no. of attendance in Accident & Emergency Department / emergency admission to medical ward / acute patient days in medical ward of those patients having at least one incidence during the 90-day post-discharge period
3. Emergency admission to medical ward also include admission to Emergency Medicine ward with subsequent transfer to Medical specialty.
4. Statistically significant (p-value < 0.05)
5. A&E Department refers to Accident & Emergency Department
Post-Discharge Emergency Admission to Medical Ward

Emergency Admission to Medical Ward in 90-day Post Discharge Period

Without EC@Home (based on model) | With EC@Home
---|---
1,574 | 1,183

Change = -391 (-25%)

With EC@Home Program, the post-discharge emergency admission to Medical Ward could be reduced by around 25%.

^ Note: Emergency admission to medical ward also include admission to Emergency Medicine ward with subsequent transfer to Medical specialty.
The post-discharge acute patient days in medical ward and attendance in A&E Department could be reduced by around 30%. 
### 90-day HARRPE Outcomes

<table>
<thead>
<tr>
<th></th>
<th>No. of events/days</th>
<th>Incident Rate</th>
<th>Average No. of event/100 Non-hospitalized FU days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Treatment (n=258)</td>
<td>Control (n=226)</td>
<td>Treatment (n=258)</td>
</tr>
<tr>
<td><strong>AED attendance</strong></td>
<td>196</td>
<td>230</td>
<td>43.41%</td>
</tr>
<tr>
<td><strong>Unplanned readmission</strong></td>
<td>143</td>
<td>168</td>
<td>34.88%</td>
</tr>
<tr>
<td><strong>Planned readmission</strong></td>
<td>60</td>
<td>120</td>
<td>16.28%</td>
</tr>
<tr>
<td><strong>Unplanned LOS</strong></td>
<td>1266</td>
<td>1490</td>
<td>34.88%</td>
</tr>
<tr>
<td><strong>Planned LOS</strong></td>
<td>351</td>
<td>453</td>
<td>16.28%</td>
</tr>
</tbody>
</table>
### It Saves Lives Too

<table>
<thead>
<tr>
<th></th>
<th>HKEC Study Cohort</th>
<th>HKEC Control Cohort</th>
<th>Change in Absolute Risk</th>
<th>Change in Relative Risk</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>h) 28-day A&amp;E admission (MED)* rate %</td>
<td>15.66</td>
<td>22.12</td>
<td>- 6.46</td>
<td>- 29.2%</td>
<td>0.0715</td>
</tr>
<tr>
<td>i) 90-day mortality rate %</td>
<td>6.02</td>
<td>11.95</td>
<td>- 5.92</td>
<td>- 49.6%</td>
<td>0.0232</td>
</tr>
</tbody>
</table>
Cost Savings in 1 cluster (11% of HA workload)

- Reduction in Readmission at least: 48.75% (1,916 cases)

- Assuming $12,140 / admission case, total annual nominal savings: $1,916 \times $12,140 = HK$23,260,240

- Manpower investment for 4 RN = HK$1,600,000
Piloted ‘Integrated Discharge Support Programme for Elderly Patients’ (IDSP) since 2008

- Funded by Labour & Welfare Bureau, supported by Elderly Commission in collaboration with Social Welfare Department

- Piloted in 3 acute hospitals: TMH, PMH & UCH since 2008 and NGOs were engaged through tendering process

- The services are led by a Program Director (geriatricians) supervising the hospital Discharge Planning Team (DPT) and a NGO Home Support Team (HST)

- Outcomes:
  - Emergency admission
  - LOS in acute ward
  - AED attendance
  - Functional outcomes
  - Health related quality of life
  - Carer’s stress

- Government had approved recurrent funding to HA for implementing the project in 15 hospitals covering all districts in Hong Kong in 2011
Strategy

- Building a comprehensive discharge planning system
- Early identification of differing needs of patients
- Provision of appropriate services within the context of services available
- Engagement of carer and patients
- Sharing of patient information with relevant stakeholders to facilitate patient care
Service offered

- Early discharge planning
- Transitional rehabilitation at the geriatric day hospitals and fast tract clinics
- Home-based community care service by NGOs
- Carers’ training and support
- Sharing of patient information through the electronic Patient Record System (ePR)
Integrated Care & Discharge Support

Risk Identification and Stratification
(Present arrangement: HARRPE score >0.2 + Clinical referral)

Comprehensive Needs Assessment

ACE protocols to improve care process
(To be developed)

Formulate discharge care plan

Sub-acute care/
Rehab/ convalescence / Infirmary

Hospital discharge

In-patient - coordinated by Link Nurses

Community - coordinated by Case Manager

CHCC, GDH, SOPC, Other out-reaching services

NGO Home Support Services (IDSP)

Case Management for Specific Diseases

Enhanced CNS
Target Patients

Age
• Elders age 60 or above

High Risk Group
• HARRPE > 0.2 or
• Clinical referral
  • High readmission risk
  • High rehabilitation needs
  • High personal care needs

Exclude
• Service users of mainstream home care services
Clinical Referral

Target group: medical patients with age >60, living in community (excluded OAH)

- Living alone & unable to cope with ADL activities
- Gross memory problems + behaviour problems
- History of repeated falls
- Recent deterioration in ADL function
- Frequent readmission
## Workflow (1)

### Assessment & Discharge Planning

<table>
<thead>
<tr>
<th>Functions</th>
<th>Difficulties encountered</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify needs</td>
<td>• Time constraint, within 48 hrs after admission</td>
<td>• Six-day service per week</td>
</tr>
<tr>
<td>• Develop care plan</td>
<td>• Refusal</td>
<td>• Provide service during long holiday</td>
</tr>
<tr>
<td>• Education/ Make referrals</td>
<td></td>
<td>• Use iPad</td>
</tr>
<tr>
<td>• liaison</td>
<td></td>
<td>• Set priority for assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To improve communication with client and carer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Departmental support</td>
</tr>
</tbody>
</table>
### Workflow (2)

#### Functions
- CGA
- Case monitoring
- Health education

#### Difficulties encountered
- Time control
- Poor compliance to advice
- Multiple needs

#### Solutions
- IT e.g. remote CMS, share folder
- Knowledge & skill transfer among disciplines
- Experienced staff with effective time Mx
- Gain trust from client and carer

---

**Case Management**

- Daily HARRPE Score ≥ 0.2

**Clinical Referral**

**Assessment & Discharge Planning**
**Workflow (3)**

<table>
<thead>
<tr>
<th>Functions</th>
<th>Difficulties encountered</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Home support service</td>
<td>• Refuse service</td>
<td>• Partially waived for special case</td>
</tr>
<tr>
<td>• Home based rehab</td>
<td>• Manpower shortage</td>
<td>• Apply for community support during hospitalization</td>
</tr>
<tr>
<td>• Transitional residential</td>
<td>• Lack of outlet to community support</td>
<td>• Utilizes SWD respite resources first</td>
</tr>
<tr>
<td>placement</td>
<td>• Limited quota in TR</td>
<td></td>
</tr>
</tbody>
</table>
Case conference
Implementation of the integrated care model in all the acute hospitals (15) in phases in 2011-12

Covering 79,100 high risk patients with 8,800 referrals to NGOs for home support services
## Integrated Care Model Project, HKEC

**Target Deliverables (1)**

The 12-month deliverables of the 3 programs are as follows:

### Integrated Care Model for High Risk Patients

<table>
<thead>
<tr>
<th>Integrated Discharge Support Program for Elderly Patients (IDSP)</th>
<th>Reducing Avoidable Hospitalization through case management</th>
<th>Enhanced CNS Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> No of patient episodes with discharge planning</td>
<td><strong>D</strong> No of patient episodes with discharge planning</td>
<td><strong>G</strong> No of patient episodes with discharge planning</td>
</tr>
<tr>
<td><strong>B</strong> Referral to NGO Home Support Services</td>
<td><strong>E</strong> No of patient episodes with case management</td>
<td><strong>H</strong> No. of patients with enhanced CNS</td>
</tr>
<tr>
<td><strong>C</strong> Transitional residential care by NGO</td>
<td><strong>F</strong> # of home visits by case managers (Ex8)</td>
<td><strong>Total # of patient episodes with discharge planning (A+D+G)</strong></td>
</tr>
<tr>
<td><strong>HKEC</strong> 4,074</td>
<td>4,244</td>
<td>1,582</td>
</tr>
<tr>
<td><strong>B</strong> 1,081</td>
<td>779</td>
<td>460</td>
</tr>
<tr>
<td><strong>C</strong> 54</td>
<td>6,232</td>
<td>9,900</td>
</tr>
<tr>
<td><strong>HKEC</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
No. of IDSP participants by type of HST services received in 2009

No. of IDSP participants

- Home visits: 2102
- Vital signs monitoring: 1329
- Telephone calls from patients/caregivers within office hour: 1134
- Delivery of meals: 856
- Escorting: 649
- Home rehabilitation: 576
- Person care: 553
- House keeping: 457
- Elderly sitting: 347
- Supporting service: 278
- Grocery Shopping: 168
- Simple wound dressing: 96
- Laundry service: 60
- Delivery of drugs or specimens: 58

Type of HST services

Remarks: based on data from 3 pilots: Kwun Tong (Q1 to Q4), Kwai Tsing (Q1 to Q4) and Tuen Mun (Q3 to Q4) in 2009
## Scales of Fee charging, NGO service

<table>
<thead>
<tr>
<th>Income Level</th>
<th>At CSSA level or below</th>
<th>Between CSSA to 1.5 CSSA Level</th>
<th>Above 1.5 CSSA Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meal delivery</td>
<td>$12.6</td>
<td>$15.4</td>
<td>$18.6</td>
</tr>
<tr>
<td>Laundry Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Light</td>
<td>$0.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>$0.90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heavy</td>
<td>$1.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Care, Home making, Elderly-sitter and Escort Service <strong>(Per Hour)</strong></td>
<td>$5.4</td>
<td>$11.7</td>
<td>$19.00</td>
</tr>
<tr>
<td>Transitional Residential Care Service <strong>(Per Day)</strong></td>
<td></td>
<td></td>
<td>$60</td>
</tr>
</tbody>
</table>
What’s changed

Patients:

✓ Services coordinated around the patients
✓ Define care plan formulated for high risk elders
✓ Shorten unnecessary hospital stay
✓ Avoid hospital avoidable re-admissions
✓ Enhance home support services
✓ Improve patient satisfaction
What’s changed

Carers

✓ Sharing of patient information
✓ Relieve stress
✓ Training & empowerment
✓ Improve carer satisfaction
Fragmented Healthcare Services
Integration via People & Data
Conclusion

- Let’s kill Fragmentation of Healthcare
- Let’s integrate People, Data and Service
- We want Integrated Care Model for Elderly Services